DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Welsh And

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 02-012

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

5. TYPE OF PLAN MATERIAL *(Check One)*: OCT - 3 2002

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 405.2400 through 42 CFR 405.2472

7. FEDERAL BUDGET IMPACT:
a. FFY 03 $ 203,000
b. FFY 04 $ 203,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B page 2a and page 10 – policy changes

Attachment 4.19B pages 2, 3 and 11 – formatting changes only.

4.19B page 2b (P+I)
4.19B page 10a (P+I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19B page 10 (P+I)
4.19B pages 2, 3, 11 (P+I)

10. SUBJECT OF AMENDMENT:

Revision of payment methodology for Federally Qualified Health Center and Rural Health Clinic Services.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Did not wish to comment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Bob Labbe

14. TITLE: Director

15. DATE SUBMITTED:

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: OCT - 3 2002

18. DATE APPROVED: ~~DEC 19 2002~~ DEC 20 2002

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL - 1 2002

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Bunnie Butterfield

22. TITLE: Associate Regional Administrator

23. REMARKS:
P&I changes authorized by the State on 12/12/02.

POSTMARKED: 9/30 (DATE) • Juneau (CITY/STATE)

FORM HCFA-179 (07-92)

Methods and Standards for
Establishing Payment Rates: Other Types of Care

Family Planning Services and Supplies

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures without an established RVU. Laboratory services are reimbursed at the lesser of billed charges or the Medicare fee schedule.

Federally Qualified Health Center Services

Payment for Federally Qualified Health Center Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System
All Federally Qualified Health Centers (FQHCs) are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the center's reasonable costs for the center's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease in the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each center fiscal year thereafter, each center will be paid the amount (on a per visit basis) equal to the amount paid in the previous center fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the center. The center must supply documentation to justify scope of service adjustments.

For newly qualified FQHCs after State fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers, and adjustments for increases or decreases in the scope of service furnished by the Center during that fiscal year.

Alternative Prospective Payment System
Beginning with the Federally Qualified Health Center's fiscal year 2003 (FY03), qualifying centers may agree to have their payment rates set using an alternative prospective payment methodology outlined below. The alternative payment methodology agreement between the State and the Federally Qualified Health Center results in payment to the FQHC of an amount at least equal to the Prospective Payment System (PPS) payment rate. The State annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for FY99 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002.

The center's allowable and reasonable costs for fiscal year 2000 are inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket, inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the center to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket , then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation. Prescription drugs are subject to drug coverage limitations in 7 AAC 43.590 and are reimbursed in accordance with 7 AAC 43.591. Hospital deliveries are reimbursed in accordance with 7 AAC 43.107(b).

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the center may apply for exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, descriptions of efforts to offset the deficiencies, and an analysis of community needs for the services.

Methods and Standards for Establishing Payment Rates: Other Types of Care

The alternative payment methodology agreement between the State and the Federally Qualified Health Center will result in payment to the FQHC of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for FQHCs becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other centers or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the center will be paid the rate it was entitled to the previous clinic fiscal year plus the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the Center during that center's fiscal year.

Home and Community-Based Waiver Services

A unit of care coordination service is reimbursed at the lesser of the amount billed the general public or the state maximum allowable for that unit of service.

A unit of specialized equipment and supplies is reimbursed at the lesser of the amount billed the general public or the state maximum allowable for that unit of service.

A unit of specialized private duty nursing service is reimbursed at the lesser of the amount billed the general public or the following state maximum allowable: registered nurse, $25 per hour; advanced nurse practitioner, $25; licensed practical nurse, $20 per hour.

A unit of environmental modifications service is reimbursed at 100 percent of billed charges up to a maximum of $10,000 per 36-month waiver period, plus an administrative fee for certain providers as approved by the managing state agency. Services must be prior authorized.

The managing state agency will determine for each provider the amount of reimbursement for a unit of adult day care, chore, habilitation, meals, respite, or waiver transportation service based on the allowable direct service costs for the service provided, plus an allowance to compensate the provider for the allowable administrative and general costs associated with providing the service.

Reimbursement for a unit of residential supported living service is determined by the managing state agency based on a daily unit of service. Rates are negotiated on a per recipient per provider per waiver year basis.

Home Health Services

Payment is made at 80 percent of billed charges.

Hospice Care Services

Payment is at the Medicaid rates published annually by the Health Care Financing Administration.

Laboratory Services

Payment for laboratory services provided by independent laboratories, physicians in private practice, and hospital laboratories acting as independent laboratories is made at the lesser of billed charges or the Medicare fee schedule. Unlisted procedures are paid at 80 percent of the amount billed to the general public.

Mammograms

Payment is made at the lesser of billed charges, the Resource Based Relative Value Scale methodology used for physicians, or the provider's lowest charge.

Medical Supplies and Prosthetic Devices

Payment for durable medical equipment and supplies and prosthetic devices is made at lesser of amount billed the general public or the state maximum allowable. Payment for unusual or custom equipment is authorized on a case-by-case basis and may not exceed the authorized amount.

Rural Health Clinic Services

Payment for Rural Health Clinic Services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.

Prospective Payment System

All Rural Health Clinic Services are reimbursed on a prospective payment system beginning with Fiscal Year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding year.

Payment rates are set prospectively using the total of the clinic's reasonable costs for the clinic's fiscal years 1999 and 2000. These costs are divided by the average number of visits for the two-year period to arrive at a cost per visit. The cost per visit is adjusted to take into account any increase or decrease in the scope of services. The cost per visit is the prospective rate for calendar year 2001. Beginning in FY 2002, and for each clinic fiscal year thereafter, each clinic will be paid the amount (on a per visit basis) equal to the amount paid in the previous clinic fiscal year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic. The clinic must supply documentation to justify scope of service adjustments.

For newly qualified RHCs after State fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar caseload, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics, and adjustments for increases or decreases in the scope of service furnished by the clinic during that fiscal year.

Alternative Prospective Payment System

Beginning with the Rural Health Clinic's fiscal year 2003 (FY03), qualifying clinics may agree to have their payment rates set using the alternative prospective payment system outlined below. The alternative payment methodology agreement between the State and the Rural Health Clinic (RHC) results in payment to the RHC of an amount at least equal to the Prospective Payment System (PPS) payment rate. The state annually evaluates the Medicare Economic Index for primary care services to insure the alternative rate is at least equal to or greater than the PPS rate.

Base rates are calculated prospectively on a per visit basis equal to 100 percent of the inflated average, as explained below, of the allowable and reasonable costs of services furnished during the center's fiscal years 1999 and 2000. The base year costs for fiscal year 1999 are inflated using the number set out in the first quarter 1999 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket inflated to 2002.

The clinic's allowable and reasonable costs for fiscal year 2000 will be inflated by the number set out in the first quarter 2000 publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket inflated to 2002. The cost per visit is then adjusted for any increase or decrease in the scope of services, based on documentation supplied by the clinic to justify such an adjustment. For each subsequent fiscal year, the payment rate is increased using the first quarter publication of Global Insight's *Health Care Cost Review,* Skilled Nursing Facility Total Market Basket and then adjusted for any increase or decrease in the scope of services. At least every four years, the department will change the base year to reflect more current cost data for establishing rates.

Prescription drugs and hospital deliveries are excluded from this payment system because they are subject to different methodologies per state regulation. Prescription drugs are subject to drug coverage limitations in 7 AAC 43.490 and are reimbursed in accordance with 7 AAC 43.591. Hospital deliveries are reimbursed in accordance with 7 AAC 43.107(b).

If the rate established using the alternative prospective payment methodology does not allow reasonable access to quality patient care provided by an efficiently and economically managed facility, the clinic may apply for exceptional relief from the rate-setting methodology. The application must include the estimated amount necessary to allow reasonable access to quality care, reasons for the relief requested, management actions taken to respond to the situation, corresponding audited financial statements, a description of other efforts to offset the deficiencies, and an analysis of community needs for the service.

Methods and Standards for Establishing Payment Rates: Other Types of Care

The alternative payment methodology agreement between the State and the Rural Health Clinic will result in payment to the Rural Health Clinic of an amount that is at least equal to the Prospective Payment System payment rate. The State will annually evaluate the alternative payment rate to ensure that the alternative rate is at least equal to or greater than the PPS rate and that it does not exceed the payment limit set under 42 CFR 447.300 through 447.371.

Initial payments for Rural Health Clinics becoming qualified after State FY00 are established by computing a state-wide weighted average payment to other clinics or by cost reporting methods if a minimum of six months of cost data for years 1999 and 2000 is submitted. For each subsequent year, the clinic will be paid the rate it was entitled to the previous clinic fiscal year increased by the percentage increase in the Skilled Nursing Facility Total Market Basket and adjusted for increases or decreases in the scope of service furnished by the clinic during that clinic's fiscal year.

Speech, Hearing and Language Services

Payment for speech-language pathology services provided by a speech pathologist or outpatient speech therapy center is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment for hearing services provided by an audiologist is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the state maximum allowable for procedures that do not have an established RVU. Payment to a hearing aid supplier is made at the lesser of billed charges or the state maximum allowable.

Substance Abuse Rehabilitation Services

The following substance abuse rehabilitation services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable:

(a) assessment and diagnosis services;
(b) outpatient services, including individual, group, and family counseling; care coordination; and rehabilitation treatment services;
(c) intensive outpatient services;
(d) intermediate services; and
(e) related medical services, including medical evaluation for admission into methadone treatment, intake physical for nonmethadone recipient, methadone treatment plan review, medication management, medication dispensing, and urinalysis and detoxification services.

Targeted Case Management

For care coordination services see Substance Abuse Rehabilitation Services.
For family and client support services see Mental Health Rehabilitation Services.

Transportation Services

Nonemergency ground ambulance service within the same community is payable at the lesser of the amount billed the general public or the state maximum of $200 per one-way trip. Nonemergency ground ambulance service outside the community and nonemergency air ambulance service is payable at the amount billed to the general public. Prior authorization is required.

Emergency ground ambulance or commercial airline service is payable at the amount billed the general public. Emergency air ambulance service is payable at the lesser of the amount billed the general public or the state maximum allowable.

Transportation costs for an escort is payable at the amount billed the general public; prior authorization is required.

Lodging and meal costs for recipients and approved escorts are reimbursed at the lesser of the amount billed the general public or the state maximum of $79 per day for lodging, or $48 per day per person for double occupancy, and $36 per day, per person for food. Lodging and meals in a prematernal home are payable at the lesser of the amount billed or the state maximum allowable all-inclusive rate of $72 per day.